THE NHS IN AN AGE OF PROGRESSIVE AUSTERITY

A joint Demos/Tribal roundtable

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INTRODUCTION

This short report summarises the discussions at a joint Demos/Tribal roundtable held on 20 October 2009 on the NHS in an age of progressive austerity.

OPENING REMARKS BY RICHARD REEVES

Richard Reeves, director of Demos, introduced the roundtable by explaining that this event was a forerunner of a wider programme of work in which Demos would examine different areas of public finances in an era of post-recession austerity. This roundtable, focusing on the NHS, is a counterpoint to another debate held by Policy Exchange – in which a different assembly of attendees discussed the future of the NHS from an alternative political perspective. Richard concluded by urging the group to consider the progressive objectives and principles of the NHS, the steps needed to preserve these and to ensure the poorest and most vulnerable are not left worse off by financial cuts. He then handed over to Professor John Appleby.

IMPLICATIONS OF A RECESSION FOR THE NHS: A FREEZE...OR WORSE?

PRESENTATION BY PROF JOHN APPLEBY, CHIEF ECONOMIST, KINGS FUND

PUBLIC FINANCES: AN OVERVIEW

Professor Appleby began by explaining the scale of the problem in terms of GDP growth, public sector debt, and fiscal tightening projections that would be needed to repay that debt.

Citing a recent IFS report, Britain’s Fiscal Squeeze: The choices ahead (September 2009), he summarised:

“If the Treasury’s analysis in Budget 2009 is correct, the crux of the fiscal problem is that the amount the Government will need to borrow to bridge the gap between its spending and tax revenue once the economy has recovered is around 6.4 per cent of national
income (or £90 billion a year in today’s terms) larger than thought in Budget 2008…

Leaving this increase in the structural deficit unaddressed would see public sector net debt rise to unsustainable levels, even if borrowing costs stay low.”

**IMPLICATIONS FOR NHS FUNDING**

Professor Appleby then went on to explain how this situation would affect the future of the NHS. First, he looked back over the history of NHS investment, through previous periods of recession. History tended to show sustained levels of investment during recessions, then reductions in the period afterwards. The current Comprehensive Spending Review had set next year's levels of NHS spending: £105bn, though this is £4bn less than planned. Options remained open as to the levels of spending beyond 2010-11.

The Kings Fund and the IFS had modelled three NHS funding scenarios for this period – “arctic”, “cold” and “tepid”.

Arctic would require spending cuts over the next six years – this had never been done in the history of the NHS. Cold would require zero growth – again, something which had never been sustained out over a six year period. Tepid would see a 2.5 per cent annual increase in NHS spending for six years, but this would still be 1.5 percentage points below the long term average.

Professor Appleby next explained how these scenarios would affect other departmental funding, and what the consequences would be for levels of taxation.

Even a period of zero growth in real NHS spending would require a 3.5 per cent annual cut in other departmental spending, whereas a modest 2.5 per cent spending increase would require a 4.5 per cent cut in non-health departmental spending. This would mean a 16 per cent real cut over a 6 year period.

In tax terms, a tepid scenario and a very modest 1.5 per cent increase in spending for other departments would require a £17.1bn tax rise, or a 4 per cent increase on VAT.

**THE FUNDING GAP**

Professor Appleby ended his presentation by discussing the funding gap within healthcare – the amount needed to meet
demographic change compared to the amount that would be provided in a funding settlement.

Demographic pressures (population growth and ageing) suggest the NHS will need real increases each year of between £1 and £2 billion just to maintain existing levels of care to larger numbers.

Using Derek Wanless’s projections of future healthcare costs, there will be a funding gap of between £4bn and £39bn by 2016, depending on tepid, cold or arctic funding settlements, and the Wanless scenario chosen (which assumes different levels of NHS productivity gains, population health, adoption of new technology, changes in life style, etc. to estimate “fully engaged”, “solid progress” or “slow uptake”).

There are two possible ways of filling this gap – increase taxes and make non-health departmental funding cuts or make efficiency savings in the NHS.

The NHS would need to make 6 per cent productivity gains annually over 6 years to fill the £40bn funding gap. But the NHS has made an average 0.4 per cent productivity loss annually between 1997 and 2007.

GROUP DISCUSSION UNDER CHATHAM HOUSE RULES (INCLUDING RESPONSE BY RT HON PATRICIA HEWITT MP)

OPTIONS FOR THE NHS

It was suggested that the NHS had three options:
1. A pay freeze for NHS staff. To be progressive this would still have to protect the lowest paid workers
2. Reform of public sector pensions
3. Make substantial productivity gains

It was widely agreed that the third of these options was the most viable and progressive, with the group feeling there was enormous scope for increased productivity in the NHS. No other sector would accept a productivity loss of 0.4 per cent year on year and the future of the NHS would very much be about value for money.
It was pointed out, however, that the NHS had only made productivity gains in two years over the past decade, and this was at best below 1.5 per cent. Nevertheless, if the “funding tap” were turned off, and the right tools, information and incentives were used, productivity gains were possible. It was suggested that substantial increases in NHS funding over the past decade has perhaps been made too quickly, so that NHS infrastructure had been unable to spend the funding effectively.

This point was illustrated by the fact that the best hospitals serve 40 per cent more day cases in gynaecology than the worst hospitals. The best 10 per cent of hospitals have an 8-9 day stay for older accident patients whereas the worst have 30 days – after which it is unlikely these patients will ever make it back home and live independently. Such differences in performance suggest productivity gains can and should be made. In some cases, beds and wards do need to be closed, though this will reduce staff, not fixed costs. Real productivity gains can only be made in the more efficient operation of services.

The case of a privately run NHS clinic in Nottingham was cited, which uses seconded NHS staff, has not cut pay or conditions, but which has made 20 per cent productivity gains.

METHODS OF IMPROVING PRODUCTIVITY

There then followed an in-depth discussion regarding some of the key methods for improved productivity within the NHS. These were identified by the group as:

1. Competition
2. Effective failure regimes
3. Incentives
4. Joint working
5. Workforce reform

COMPETITION

• It was noted that there were three drivers of productivity:
1. Culture – this had been tried, but could only make small gains in a centralised system.

2. Information – such as the electronic information system in the US. These programmes had made micro-level gains.

3. Incentives – this is where macro gains can be made. Naming and shaming had had a limited impact, but competition was key.

- It was agreed that the NHS already has strong competition, and so the question posed was that if competition was the key to improved productivity going forward, how would this be different to what is in place at the moment? Would it be enough to bring about huge change or did we need more collusive behaviour, as one attendee suggested? Finally, it was asked: can competition be “progressive”?

- Some felt that although competition was embedded in the NHS, fewer tenders were placed in the private sector this year than last year, for example. There was a need for a different approach to competition.

- It was also argued that competition is progressive. At the time of Kinnock and Blair reforms, Labour had to consider whether they were on the side of the provider or consumer. Being on the side of the consumer, or service user, and particularly those who are vulnerable and poor, meant promoting competition and commissioning in a way that achieved the best services – whether that came from the private, third or statutory sectors. However, this argument has not been articulated for a number of years.

FAILURE REGIMES

- Competition will inevitably lead to some decommissioning of services, perhaps closure of excess capacity within the acute sector.

- However, there is currently no effective failure regime, with no effective shareholder oversight from Foundation Trust boards, to enable effective decommissioning. Oversupply is not an inherent problem, as long as there are mechanisms in place to deal with the
oversupply when it becomes a problem. This was easier in a time of growth, and now this needed to be dealt with.

- All closures at this time will look like a cost cutting exercise. As such, there needs to be clinical, not managerial justification for closure, backed by trusted professional judgement. The estate must also be used more creatively, because hospitals do not shut per se, but rather are used differently.

**INCENTIVES**

- Some attendees felt competition was not the entire solution – if the same staff, and ex-NHS and seconded NHS staff, could achieve significant productivity gains within private settings, why can this not be done in the NHS? Management systems and targets are clearly a problem, as well as scale. It is important to look at what is holding back the same people within the main organisational structure of the NHS.

- Others agreed there were too many and not the right targets. The same staff might be far more productive in a private setting not because of competition, but because of clarity of objectives. The NHS needs a clear ten year strategy which does not include upheaval and reform.

- One attendee cited a local response to “swine flu” in one particular area, which had to be implemented before central processes were in place, as demonstrating that efficient local responses to reorganisation can be achieved when the right incentives are in place.

- Nevertheless, some attendees felt that interventionist and collusive “top down” direction would be needed, alongside powerful incentives. This was because multiple reforms in the NHS meant there was a “survivor instinct” among some NHS staff, and survivors of reform tended to be risk averse and less likely to innovate. This had lead to a cultural problem, where tried and tested methods and commissioning are relied upon. Top down direction would therefore sometimes be needed to drive the innovation required to create productivity gains.
SHIFTING FROM ACUTE SETTINGS

- Attendees agreed that a significant opportunity for improved productivity within the NHS would be to shift care from acute and secondary settings to community settings.

- One attendee cited a recent review of hospitals, which found 30-40 per cent of patients did not need to be there – they had either been admitted unnecessarily or were staying too long. These rates are similar to those found by Kaiser in California – and this provider found it could look after patients at home for half the cost of keeping them in acute settings. These gains are on a scale needed in the NHS.

- BUPA homecare in the UK has found similar levels of cost savings (50 per cent) for cancer patients being cared for at home and in piloted “virtual wards” rather than in hospital.

- Gains can be found particularly in the community and social care interface with health, such as end of life care. Shifting this from secondary to community care could potentially create huge efficiency gains.

- The possibility was raised of using existing NHS surpluses to drive this step and shift care out of hospitals and into the community as an immediate measure. This was in line with other attendees who mentioned the need to invest early in order to make cost savings later on – the example of radiotherapy was given.

JOINT WORKING

- Another area identified as generating substantial productivity gains, particularly in the longer term, was in the joint working of health and social care.

- It was questioned, for example, whether reforms of the tariff would adequately incentivise local authorities to invest in telecare and intermediate support to help patients return home. Shared incentives and pooled budgets between health and social care, in order to share efficiency gains, were vital to drive these investments.
• Joint local authority and NHS commissioning and budgeting was identified as a key long term goal. Much could be learnt from those local authorities who have joint teams and staff in place already.

• The NHS estate is not currently being used effectively in its interface with social care, and there was a need for a 10 year strategy for this – the current financial downturn could actually give policy makers an opportunity to think about these longer term and bigger picture reforms.

WORKFORCE REFORM

• There were concerns that, as a very large employer, productivity gains in the NHS would imply workforce reform – either employing fewer staff or paying them less. Progressive workforce reform was a significant challenge. Recruitment freezes, for example, often meant talented staff would move and less talented stayed, and a generalist middle management remains and loses motivation.

• Other attendees disagreed, however, noting that workforce reform was not just a matter of staffing levels and pay, but also outputs. Productivity gains had been achieved by private providers without changes to pay and conditions. Changing staff roles to drive the shift from acute to community care, for example, would certainly an upheaval, but this did not imply significant cuts in numbers of staff

OTHER POSSIBLE AVENUES FOR INCREASED PRODUCTIVITY

In addition to the methods discussed in depth, other ideas were raised, including:

• The tariff – next year’s four-year tariff will drive towards financial best practice. Those hospitals that cannot get their finances in order may face ruin – this could be problematic.
• Strengthened PCT commissioning – giving responsibility to the purchaser, not provider (GP budgets were seen as likely to have limited impact in this case).

• In the medium and longer term, personal budgets and possibly private top-ups.

• More radical steps, such as a mixture of social and private insurance, were deemed potentially inequitable and unlikely to be necessary.

• It was felt that the financial crisis itself was a good lever to drive productivity – the momentum of the crisis could be built upon to drive systemic and cultural change. However, the point was raised that within a 4-5 year electoral timeframe, the window for unpopular decisions is two years, perhaps three years maximum. There is a risk that there will be a wasted year this year, or possibly for the next two years, if a Conservative government comes into power in 2010.

• Hypothecated taxation (most probably as a slice of income tax) was suggested to be the most progressive long term solution to increasing NHS funding. This would preserve the NHS as free at the point of need, but would harness society’s desire to spend more on healthcare as they become wealthier. This is likely to be a solution not for the next government, but the one after.

• It was asked whether the Kings Fund or IFS had modelled the potential cost savings of preventative and public health programmes. It was agreed that the evidence base for preventative programmes was weak – there are lots of micro level examples, but it was very hard to see these at macro level. The smoking ban seems to have made a positive impact, but dealing with obesity, for example, would require a level of regulation in the food industry that might not be politically acceptable. This was countered by those felt that we should be more optimistic about behavioural change when it came to changing the NHS’s future cost base – the road safety campaign was a hugely successful example of accident prevention, and policy makers needed to look outside of the NHS for examples of successful approaches.
Finally, a number of obstacles to improved productivity were also identified:

- The key obstacle to NHS staff buy in was agreed to be “mixed messages” from the Government – NHS managers were never given a presentation like Professor Appleby’s. In other words, the scale of the funding gap, the reality of likely cuts and need for improved productivity had never been “spelled out” by government to PCTs or Foundation Trusts. This was countered, however, but those who felt Foundation Trust chief executives may be looking for excuses not to take action – claiming mixed messages from government may be one such excuse, whereas in fact all NHS managers should very well know the reality of the situation they face.

- It was acknowledged, however, that the Government had been ambiguous in recent years regarding it’s stand on competition in the NHS. The progressive case for competition was not longer articulated. The NHS already had plurality within the market, but government had “taken their foot off the accelerator” when it came to finalising competition reform and were issuing mixed messages, for example regarding “preferred providers”, which were not helpful.

- The point was raised that global equity group invest in healthcare all over the world – and the fact that few investors had come to the UK for this reason was a problem for UK plc and needed reviewing. External investment could ease capital costs considerably.

- There was a growing problem that a smaller and smaller working population was supporting an older retired population – the intergenerational equity problem was identified as significant challenge to the NHS in the future. The NHS contract would need to be reviewed in light of this.

**CONCLUDING THOUGHTS**

Overall, there was a consensus among the assembled experts that the NHS faces serious, deep and long term financial challenges, and doubts as to whether NHS managers were ready for the cuts and changes in working this would necessitate at the end of the current CSR.
Nevertheless, it was widely agreed that the capacity for improved productivity was substantial, with several ideas for short and longer term productivity gains arising as part of the debate.

The key would be to ensure that these changes in working – particularly regarding the longer term shift from acute to community care and improved interface with social care – were taken fairly and equitably, ensuring both the most vulnerable patients and lowest paid health and social care workers were not unduly affected.
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